

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30061**

Registrar's No. **742A**

Registration District No. **5466**

Primary Registration District No. **5466**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **S. Campbell Twp. Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Medical Center for Federal Prisoners
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 months, 5 days**
(Specify whether
In this community **5 months, 5 days**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **31**
(b) County **31**
(c) City or town **Guantanamo or Havana (?) Cuba**
(If outside city or town limits, write "RURAL")
(d) Street No. **31**
(If rural, give location)
(e) Citizen of foreign country? **Yes** (Yes or No)
If yes, name country **Cuba**

3. (a) PRINT FULL NAME **Carlos Creache Y. Planche #5600-H**

3. (b) If veteran, name war **3. (c) Social Security No.**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **6. (c) Age of husband or wife if alive** years

7. Birth date of deceased **November 2 1915**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 10 7 hr. min.

9. Birthplace **Guantanamo Cuba**
(City, town, or county) (State or foreign country)

10. Usual occupation **Odd Jobs**

11. Industry or business

12. Name **Juan Creache**

13. Birthplace **Cuba**
(City, town, or county) (State or foreign country)

14. Maiden name **Virginia Planche**

15. Birthplace **Cuba**
(City, town, or county) (State or foreign country)

16. (a) Informant **File**

(b) Address **MCFP**

17. (a) **Burial** (b) Date thereof **Unknown**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Shipped to New York, N.Y.**

18. (a) Signature of funeral director **ALMA LOHMEYER FUNERAL HOME**

(b) Address **SPRINGFIELD, MISSOURI**

19. (a) **9-15-46** (b) **W. E. Handley M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **9**
year **1946** hour **8** minute **50** P.A.M.

21. I hereby certify that I attended the deceased from **April 4**
1946 to **September 9, 1946**;
that I last saw him alive on **September 9, 1946**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculous meningitis** Duration **5 days**

Due to **Tuberculosis, pulmonary, active, bilat., far advanced, with cavitations.** 8 mo.

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **W. E. Handley M.D.** (M. D. **REGISTERED**)

Address **Medical Center Fed. Pris.** Date signed **9-14-46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Frank Gable*

Licensed Embalmer No..... *4140*

P. O. Address..... *Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

- - If this body, is not embalmed, fact should be so stated above.

x